Walgreens
Healthcare Plus

1 1 3 0 0 W H P W H P 2 6 7

REGISTRATION & PRESCRIPTION ORDER FORM

Please **PRINT** clearly using **UPPERCASE** letters. Use black ink only. Enclose this form with your mail service prescription.

CITY OF TEMPE

GROUP NO.: 512220 INTERCOM: WHP UPI: WHP267

___ - __ - ____

MEMBER SOCIAL SECURITY NUMBER (VERY IMPORTANT)

Please complete both pages of this form.

#1 MEMBER INFORMATION

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female

__ / __ / ____

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ No Known ☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

HEALTH CONDITIONS: ☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease ☐ 500-Glaucoma ☐ 600-Stomach Disorders ☐ 700-Thyroid Disease ☐ 800-Arthritis ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand drugs whenever possible. You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise (see below).

☐ *By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. By making this choice, I understand that under my benefit plan, if my physician allows a generic substitute but I elect to receive a brand drug, I am responsible for the brand copayment plus the difference between the brand and generic price for each drug.

PAYMENT (required at time of order):

Rx Type	No.	Cost (ea.)	Subtotal
Brand		**$30.00***	$
Generic		**$14.00**	$
TOTAL AMOUNT ENCLOSED			$

Signature (for credit card):

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express; **no cash, please)** CREDIT CARD EXPIRATION

____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ __ / __

Checks payable to: **Walgreens Healthcare Plus** P.O. Box 29061, Phoenix, AZ 85038-9061

CUSTOMER SERVICE: 1-888-265-1953 (☎ TTY for deaf: 1-800-573-1833)

REFILLS BY PHONE: 1-800-RX-REFILL (1-800-797-3345) (en español: 1-800-778-5427)

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

Thank you for your order. Please allow two weeks for delivery from the date you mail your order.

I/6-02

1 1 4 0 0 W H P W H P 2 6 7

#2 Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#3 Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#4 Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

#5 Dependent Information

Name (First, Last)

E-mail Address

Date of Birth (MM/DD/YYYY) / / ☐ Male ☐ Female

Address (please do not use P.O. Box)

City | State | ZIP Code

Daytime Phone ( ) | Evening Phone ( )

ALLERGIES: ☐ 70-Penicillin ☐ Other (list):
☐ No Known ☐ 87-Sulfa
☐ 32-Codeine ☐ 93-Tetracycline

HEALTH CONDITIONS: ☐ 500-Glaucoma
☐ No Known ☐ 600-Stomach Disorders
☐ 200-Diabetes ☐ 700-Thyroid Disease
☐ 300-Hypertension ☐ 800-Arthritis
☐ 400-Heart Disease ☐ Other (list):

☐ Check if prescription(s) enclosed for this patient and print:

Dr. Name | Dr. Phone (very important) ( )

☐ Check if this patient needs snap-on caps.

Please complete both pages of this form.